



Disability Retirement Election Application

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

☐ Check if this is an employer-originated application.

Employer must fill out and sign Section 11 on the last page of this application.

Application Type

☐ Disability Retirement

☐ Industrial Disability Retirement

☐ Service Pending Disability Retirement

☐ Service Pending Industrial Disability Retirement

Section 1

Please provide your full name including middle initial.

Display all dates in this order: month/day/year.

Member Information

Name of Member (First Name, Middle Initial, Last Name)		Social Security Number	
Address			
City	State	ZIP	Country
Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone () ()	Work Phone () ()

Section 2

Provide your last day on payroll only if you left employment four months ago or longer.

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Information

Retirement Date (mm/dd/yyyy)	Last Day on Payroll (mm/dd/yyyy)
Employer	Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?
☐ No ☐ Yes, from Beginning Date (mm/dd/yyyy) to Ending Date (mm/dd/yyyy) .

Are you a member of a California public retirement system other than CalPERS? ☐ No ☐ Yes, provide:

Name of System		
Date of Retirement (mm/dd/yyyy)	Beginning Service Credit Date (mm/dd/yyyy)	Ending Service Credit Date (mm/dd/yyyy)

Section 3

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Information

Workers' Compensation Carrier		
Name of Adjuster	Phone Number () ()	
Address		
City	State	ZIP
Claim Number(s) Relating to Alleged Disability	Date of Injury (mm/dd/yyyy)	

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 4

Disability Information

Please complete all the
questions below. If you
need additional space,
attach separate sheets
and be sure to include your
name and Social Security
number on all sheets.

What is your specific disability; when and how did it occur?

What is the complete name and address of your treating physician(s)?

Name of Treating Physician

Medical Record Number

Address

City

State

ZIP

()
Phone Number

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? ☐ No ☐ Yes (If yes, CalPERS has a potential "right of subrogation.")

Section 5

Select **only one** payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

These options apply to Option 4 **Individual Lifetime Beneficiary** only.

This option applies to Option 4 **Multiple Lifetime Beneficiaries** only.

These options apply to Option 4, **Court Ordered Community Property** only.

Select Your Retirement Payment Option and Beneficiary

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please see pages 13 to 17 for more information on this section.

- ☐ **Option 1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 2** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 2W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 3** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 3W** - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Unmodified Allowance Option** - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.
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- ☐ **Option 4, Individual Lifetime Beneficiary** - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.
- ☐ **Option 2W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 3W & Option 1 Combined** - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
- ☐ **Specific Dollar Amount to Beneficiary** \$ _____ - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* Dollars
- ☐ **Specific Percentage to Beneficiary** _____ % - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* Percent
- ☐ **Reduced Allowance for Fixed Period of Time** _____ through _____
Percent or Dollars Date (mm/yyyy)
- If naming a beneficiary, to complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*.
- ☐ **Reduced Allowance upon death of retiree or beneficiary:** \$ _____ reduction amount
Dollars
- To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

-
- ☐ **Option 4, Multiple Lifetime Beneficiaries** - To complete this option choice, you must also fill out Section 5b *Multiple Lifetime Beneficiaries*.

-
- ☐ **Option 4, Court Ordered Community Property** - If you select this option, you must also complete section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Community Property options.
- ☐ **Option 4/Unmodified** - There is no additional beneficiary designation for this option.
- ☐ **Option 4/1** - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
- ☐ **Option 4/2W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- ☐ **Option 4/3W** - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 5a

Individual Lifetime Beneficiary

Designate one beneficiary
and provide all of that
person's information
including full name.

Complete this section only if you chose either Option 2, 2W, 3, 3W or Option 4 Individual Lifetime Beneficiary or
Option 4/2W or 4/3W Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Section 5b

Multiple Lifetime Beneficiaries

If you want your
beneficiaries to receive
an equal share of your
benefits, do not specify
a dollar or percentage
of benefit.

Complete this section only if you selected Option 4 Multiple Lifetime Beneficiaries.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	Dollar/Percent of Benefit
Address			
City	State	ZIP	Country

Section 5c

Court Ordered Option 4 Community Property Beneficiary

List only the
Option 4 beneficiary
that is required by your
court order.

Complete this section only if you selected Option 4 Court Ordered Community Property.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 5d

Designate up to
two beneficiaries
here. If you want to
designate more than
two beneficiaries. See
page 17 for information
on completing the
Lump Sum Beneficiary
Designation form.

Option 1 Balance of Contributions Beneficiary(ies)

Complete this section only if you selected **Option 1**, **Option 4-2W/1** or **3W/1 combined**. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to pages 16 and 17 of this booklet.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Section 6

**All Applicants must
complete this section.**

Designate your beneficiary
to receive your lump sum
Retired Death Benefit.

Retired Death Benefit

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to page 17 of this booklet.

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Name (First Name, Middle Initial, Last Name)		Social Security Number	
Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female Gender	Relationship to You	
Address			
City	State	ZIP	Country

Your Name

Social Security Number

Section 7

Survivor Continuance

Please answer
all five questions and
complete the information
in each section where you
answered "Yes."

Please see page 18 for more information on this section.

1. Will you be married on, and at least one year prior to, your retirement date? ☐ No ☐ Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name)	Social Security Number
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Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Marriage
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2. Will you be registered with the California Secretary of State as being in a domestic partnership on and at least one year prior to your retirement date? ☐ No ☐ Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name)	Social Security Number
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Birthdate (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Registered Partnership (mm/dd/yyyy)
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3. Do you have any natural or adopted children under age 18 who have never been married?
☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
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Name of Child (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
---	------------------------	------------------------

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? ☐ No ☐ Yes, provide:

Name of Child (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
---	------------------------	------------------------

Name of Child (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
---	------------------------	------------------------

5. Are your parents dependent upon you for one-half of their support? ☐ No ☐ Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
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Name of Parent (First Name, Middle Initial, Last Name)	Social Security Number	Birthdate (mm/dd/yyyy)
--	------------------------	------------------------

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 8

Employer Certification (For service pending applications only)

Have your employer
complete this section.

Please see page 18 for more information on this section.

This certification is
not required if you
were separated from
employment more than
four months ago.

Employee's Last Day on Payroll (mm/dd/yyyy)

Employee's Separation Date (mm/dd/yyyy)

Balance of unused sick leave days on employee's date of separation _____
Days

Balance of educational leave days on employee's date of separation _____
Days

By signing below, you hereby certify, under the penalty of perjury, that the above information is true, complete, and correct to the best of your knowledge. Any changes to this information must be submitted on an Amended Employer Certification form.

Signature of Employer

Print Name (First Name, Middle Initial, Last Name)

Position Title of Employer

Phone Number of Employer

Date (mm/dd/yyyy)

Section 9

Tax Withholding Election

Do not complete for
industrial disability
retirement.

Federal Income Tax information. Please see page 19 for more information on this section.

Please choose one only.

☐ Do not withhold federal income tax.

☐ Withhold federal income tax in the amount of \$ _____ per month.
Dollars

☐ Withhold federal income tax based on the tax tables for:

☐ A married individual with _____ tax withholding exemptions.
Number

☐ A single individual with _____ tax withholding exemptions.
Number

In addition to the amount withheld based on the tax tables, withhold \$ _____ per month.
Dollars

State withholding
is optional for
out-of-state residents.

State Income Tax information. Please see page 19 for more information on this section.

☐ Do not withhold State of California income tax.

☐ Withhold State of California income tax in the amount of \$ _____ per month.
Dollars

☐ Withhold State of California income tax based on the tax tables for:

☐ A married individual with _____ tax withholding exemptions.
Number

☐ A single individual with _____ tax withholding exemptions.
Number

In addition to the amount withheld based on the tax tables, withhold \$ _____ per month.
Dollars

☐ Withhold State of California income tax in the amount of 10 percent of the federal income tax withholding amount.

Put your name and
Social Security number
at the top of every page.

Your Name

Social Security Number

Section 10

**This section must
be completed or
your application will
be returned.**

If your spouse's or
domestic partner's
signature is not available,
see page 21 for
instructions on completing
the Justification for
Absence of Signature form.

Your signature and your
spouse's or domestic
partner's signature must
be notarized or witnessed.

Member Signature and Notary

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand that to cancel this application I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

See page 19 for more information on this section.

Are you legally married or have a legal domestic partner? ☐ No ☐ Yes

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: ☐ Never Married/or in Partnership ☐ Divorced/Annulled ☐ Widowed

Signature of Member

Date (mm/dd/yyyy)

Signature of Spouse or Domestic Partner

Date (mm/dd/yyyy)

Notary

State

County

On _____ before me _____, personally known to me or
Date Name of Notary/Witness

☐ Proven to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Notary Seal

Witness my hand and official seal OR authorized CalPERS representative signature.

Signature of Notary or Representative

Position Title

Date (mm/dd/yyyy)

If this is an employer originated application, employer must fill out Section 11 on the next page.

Section 11

To be completed if the
employer is submitting
the application on behalf
of the member.

Employer-Originated Applications

Signature of Employer

Print Name of Employer

Position Title of Employer

()
Phone Number

Date (mm/dd/yyyy)

Mail to:

CalPERS Benefit Services Division • P.O. Box 942711, Sacramento, California 94229-2711